Case 4:07-cv-04925-CW E

Document 2-4

Filed 09/21/2007

Page 1 of 12

EXHIBIT

INMATE APPEAL ASSIGNMENT NOTICE

Date: June 14, 2006

To: INMATE WOODSON, P76095

Current Housing: D8-124

From: INMATE APPEALS OFFICE

Re: APPEAL

ASSIGNED STAFF REVIEWER: CTC

APPEAL ISSUE: MEDICAL

Inmate WOODSON, this acts as a notice to you that your appeal has been sent to the above staff for INFORMAL response. If you have any questions, contact the above staff member. If dissatisfied, you have 15 days from the receipt of the response to forward your appeal to this office for the FIRST level of review.

T. VARIZ, CC-II / E. MEDINA CC-II Appeals Coordinators Salinas Valley State Prison STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

PART I: TO BE CO			
A fee of \$5.00 may be charged to			
If you believe this is an urgent/emergent hea		ntact the correction	onal officer on duty.
REQUEST FOR: MEDICAL ☐ MENTAL H	EALTH 🗆	DENTAL □	MEDICATION REFILL
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PART III: TO BE COMPLETE	O AFTER PATI	ENT'S APPOIN	TMENT
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STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE ŠERVICES REQUEST FORM

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STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

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STATE OF CALIFORNIA CBC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

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Page 7 of 12

STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

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REQUEST FOR: MEDICAL			
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STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

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STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

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PART I: TO BE COM	PLETED BY THE PATIENT			
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If you believe this is an urgent/emergent healt	h care need, contact the correctional officer on duty.			
REQUEST FOR: MEDICAL ☐ MENTAL HE				
NAME CDC NUMBER				
WardSON 1-70	6095 0-2-127			
PATIENT SIGNATURE,	DATE			
The De				
REASON YOU ARE REQUESTING HEALTH CARE SERVICE	ES. (Describe Your Health Problem And How Long You Have Had			
The Problem)	25. (2 shorts to the free free free free free free free fr			
tollow UP ON M.	Rock Paid Have NO			
Monthage Destil	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
1-11/1833 DACK 151)	NJUVECI .			
	A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON			
BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM				
	AFTER PATIENT'S APPOINTMENT			
Visit is not exempt from \$5.00 copayment. (Send pink of	copy to Inmate Trust Office.)			
PART II: TO BE COMPLETED B	Y THE TRIAGE REGISTERED NURSE			
Date / Time Received:	Received by:			
Date / Time Reviewed by RN: 7-1-66 [4]	Reviewed by:			
S:	Pain Scale: 1 2 3 4 5 6 7 8 9 10			
<u>kan di kacamatan di</u>	on the state of th			
O: T: P: R: BP:	WEIGHT:			
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P: Meds abordered. MD X147	or Chrono reven			
☐ See Nursing Encounter Form	· · · · · · · · · · · · · · · · · · ·			
E:				
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A Section 1997				
APPOINTMENT EMERGENCY	URGENT ROUTINE			
SCHEDULED AS: (IMMEDIATELY)	(WITHIN 24 HOURS) (WITHIN 14 CALENDAR DAYS)			
REFERRED TO PCP: NID 7/5/06 Char.	DATE OF APPOINTMENT:			
COMPLETED BY	NAME OF INSTITUTION			
C.Flynn RN	1) 1/5r			
PRINT / STAMP NAME SIGNATURE / TITLE	DATE/TIME COMPLETED			
C.Flynn RN	7/5/06			
CDC 7362 (Rev. 03/04) Original - Unit Health Record Yellow - Imma	e (il copayment applicable) Pink - Inmate Trust Office (if copayment applicable) Gold - Inmate			

STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

		DMPLETED BY THE PATIENT		
A fee of \$5.00 may be charged to your trust decount for each health care visit.				
		ealth care need, contact the correcti		
REQUEST FOR: ME		HEALTH DENTAL DENTAL	MEDICATION REFILL	
NAME Wyddon)	CDC NUM	BER 95	HOUSING -2-/27	
PATIENT SIGNATURE	1		DATE	
Thomas Dilivo	Um		113/06	
REASON YOU ARE REQUES	TING HEALTH CARE SERV	ICES. (Describe Your Health Probler	n And How Long You Have Had	
The Problem)				
Third	SI'P NEC	d refill ON	Pain Medication	
Donce 1	aclofoN/T	huprofort	,	
A PERSON A		34/10/		
	Land to the state of the state			
NOTE: IF THE PATIENT IS UN BEHALF OF THE PATIENT AND	ABLE TO COMPLETE THE FO	RM, A HEALTH CARE STAFF MEMBE	R SHALL COMPLETE THE FORM ON	
		ED AFTER PATIENT'S APPOI	NTMENT	
		nk copy to Inmate Trust Office.)		
		D BY THE TRIAGE REGISTER	RED NURSE	
	79N 06 Q 12			
Date / Time Reviewed by RN:	7-4.06	Reviewed by:		
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<u>o.</u>		Team Boote.		
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☐ See Nursing Encount	er Form			
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APPOINTMENT	EMERGENCY	URGENT	ROUTINE	
SCHEDULED AS:	EMERGENCY (IMMEDIATELY)	(WITHIN 24 HOURS)	(WITHIN 14 CALENDAR DAYS)	
REFERRED TO PCP:		DATE OF APPOINTMENT:		
COMPLETE CHELYNN RN		NAME OF INSTITUTION		
	·	1/71/5/		
PRINT / STAMP NAME RN	SIGNATURA/ TET	E ,	DATE/TIME COMPLETED	
C'EIAMI E			1 115/170	
CDC 7262 (Dev. 02/04)		(if continuity) Dist. Lamata	Cold Jumpto	

STATE OF CALIFORNIA CDC 7393 (11/02)

NOTIFICATION OF DIAGNOSTIC TEST RESULTS

NAME WOODS	EDC NUMBER
INSTITUTION SVSP	HOUSING
TYPE OF TEST	DATE OF TEST SQ
YOUR TEST RESULTS HAVE BEEN EVALUATED FOLLOWING HAS BEEN DETE	
Your test results are essentially within normal limits or are required. You are being scheduled for a follow up medical appoint indicating your appointment time. A repeat test will be ordered. You will be ducated for this	ntment. You will be receiving a ducat
A chronic care appointment has been scheduled for you. Your appointment time. NAME / TITLE	You will be receiving a ducat indicating
PHYSICIAN SIGNATURE	6/19/0Ce
ONIGHT COLUMN CANADY Cabaddan Dink .	Dations